Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health and Associates

Respondent Name
Hartford Insurance Company

MFDR Tracking Number
M4-13-1965-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These dates of service were performed within the authorized timeframe and was denied in error. Denying preauthorized health care services is an administrative violation in accordance with Rule 133.301(a)."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that The Hartford upholds our denial of services. Enclosed please find a copy of the PLN11 filed on 08/16/2012 for your review."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 20012	90806	$125.00	$125.00
September 19, 2012	90806	$125.00	$125.00
TOTAL		$250.00	$250.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedure for Medical Bill Processing/Audit by Insurance Carrier.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
4. 28 Texas Administrative Code §134.203 sets out the Medical Fee Guideline for Professional Services.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 165 – Payment denied/reduced for absence of or exceeded referral. Reimbursement has been denied because the provider is not approved for payment.

Issues

1. Did the insurance carrier submit documentation to support the denial of extent of injury?
2. Did the requestor obtain preauthorization for the disputed services?
3. Did the insurance carrier submit sufficient documentation to support that requestor exceeded the preauthorization referral?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.240 "(h) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that: (1) the injury is not compensable; (2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or (3) the condition for which the health care was provided was not related to the compensable injury."

   To determine whether an extent-of-injury related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable 28 Texas Administrative Code §133.240 (h) addresses actions that the insurance carrier is required to take, during the medical bill review process when the insurance carrier determined that the medical service was not related to the compensable injury.

   Review of the initial and reconsideration EOBs submitted by both the requestor and the respondent do not contain denial reasons disputing Compensability, Extent of Injury and or Liability (CEL). The denial reason presented by the insurance carrier in the position summary to Medical Fee Dispute Resolution is therefore not supported. The services are therefore reviewed per applicable Division rules and statutes.
2. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   Review of the submitted documentation supports that the requestor obtained preauthorization for the disputed CPT code 90806. The Hartford issued a preauthorization letter dated August 14, 2012 preauthorizing 6 units of CPT code 90806 with a start date of August 14, 2012 and an end date of October 14, 2012. The requestor rendered CPT code 90806 on September 12, 2012 and September 19, 2012. As a result, the services were rendered within the preauthorized timeframes.
3. The insurance carrier denied the disputed CPT codes 90806 with denial reason code "165 – Payment denied/reduced for absence of or exceeded referral. Reimbursement has been denied because the provider is not approved for payment."

   Review of the submitted documentation contains insufficient documentation to support that the requester exceeded the preauthorized timeframes. As a result, the disputed charges are therefore subject to review pursuant to 28 Texas Administrative Code §134.203.
4. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT code 90806 is $129.17. The requestor seeks $125.00, therefore this amount is recommended for date of service September 12, 2012 and September 19, 2012.

Review of the submitted documentation finds that the requestor is entitled to a total reimbursement amount of $250.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $250.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 15, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.